



BUREAU TALK

Volume 9, Issue 3

JULY 2009

www.dhss.mo.gov/HomeCare



Inside this issue:

Disaster Preparedness	2
Disaster Preparedness Cont.	3
Stamped Physician Signatures	3
Discharge for Cause	4
Hospice/LTC Coordinated Task	5
Enticements/Inducements	5
Hospice Q & A's	6
Hospice Webinar Training	6
Durable Power of Attorney	6
Hospice Tags	7
Volunteers	7
Volunteers and Electronic Records	7
Hospice Policies and Procedures	7
Advance Beneficiary Notices	8
Durable Medical Equipment	8

INTRODUCTION

Summer has come and is quickly passing us by. The Bureau hopes everyone has had a chance to bask in the sun and enjoy some relaxation!

We are pleased to announce that there have been no recent staff changes! The Bureau anticipated hiring a registered nurse surveyor to fill the vacancy left when Claudette Jensen retired. Because of departmental budget issues, the position is not being filled at this time.

HOME HEALTH ISSUES

HOME HEALTH RULES

The amended State Home Health Regulations (19 CSR 30-26.010) were published May 31, 2009. The change that will most affect agencies is in the area of Alzheimer's training. There are now specific guidelines for Alzheimer's/Dementia training added. Most of the information is the same as found in the Missouri Revised Statutes, Chapter 660, Section 660.050; however, the new Code of State Regulations (CSR) specifically states that the training shall be provided annually and updated as needed. It also specifies what type of training is required in order to be an instructor of the training. Please find a copy of the new rules attached. (Attachment 1)

OASIS C

Are you getting ready for OASIS C? January 1, 2010 will soon be approaching! All home health agencies should be working on ways to make the implementation of OASIS C as smooth as possible.

Please see the "News from the Moo Arena", (Attachment 2), for updates on OASIS C and upcoming training opportunities, as well as, technical issues associated with the transition.

DISASTER PREPAREDNESS

With the dawning of the H1N1 virus, worldwide pandemic has arrived. Fortunately, most cases have involved mild symptoms. But the possibility that the virus will become more virulent is of utmost concern for the Department of Health & Senior Services (DHSS). Lisa Coots, Bureau Administrator, serves on a committee that the Department of Health and Senior Services (DHSS) is heading. The focus of the committee is *Palliative Care during a Pandemic*. This group of approximately 50 people is comprised of representatives from DHSS, Emergency Medical Systems (EMS), University of Missouri, long-term care facilities, hospitals, and in-home programs, physicians from Epidemiology, Director of Center of Health Ethics, law enforcement and others. The committee was designed to ensure that all providers are ready to provide palliative care in the event of a pandemic flu disaster in the state of Missouri.

Following are some of the items the bureau is focusing on and would like for all agencies to think about and discuss internally. These ideas could perhaps assist you in updating your own disaster preparedness plans.

- ❑ Have you reviewed your current clinical practice guidelines and updated policies and procedures to prepare staff during a pandemic flu?
- ❑ Have you provided continuing education to your staff regarding palliative care? (For hospices this is already part of your day-to-day work.)
- ❑ Have you provided adequate training to staff so they know what the plan will be and how to respond?
- ❑ What are you teaching regarding infection control during a pandemic?
- ❑ What kind of occupational planning are you doing?
- ❑ Are you cross training staff so if scope of practice was relaxed, disciplines other than nurses could provide palliative care?
- ❑ During a pandemic, there will probably still be a means of communication. Have you identified e-mail addresses for your patients and families so that if your staffing is low and visits cannot be made or phone calls cannot be taken, you could possibly do a mass e-mail to your patients/families giving instructions of how to keep people comfortable if they were dying and no medical staff could help?
- ❑ Have you thought about how to triage your patients? Will you discharge those less sick to be able to take on more of the very ill?
- ❑ Do you have a list of all staff's cell phones and patient's cell phones, so that if half of your staff are ill or caring for an ill family member they could possibly work from their home (call patients) with little notice?
- ❑ Do you have a tree of who is in charge, or a pecking order that all staff is aware of? If your agency is down to only half staff or less, would everyone know what the plan is and who is in charge?
- ❑ Does your agency have a contact person at the county public health department that they have been working with and know on a first name basis? Since local health departments will be receiving many of the supplies, knowing these resources during a pandemic is a must!
- ❑ Have you planned on how many patients you could admit in a day if you were fully staffed and what would that number be if you were down to half staff? At what point might you need to stop taking any new admissions? What do you feel is the maximum number of patients you could care for?
- ❑ Have you come up with a very simple paper trail for documentation, since the bureau won't expect agencies to do the massive documentation that is required at this time?
- ❑ Do you have volunteers that have said they would help during a pandemic?
- ❑ For those of you that are home health agencies...have you thought about or have you contacted a physician who would work as your medical director and would be willing to write orders; scripts for antivirals, morphine, etc. for patients he or she has never seen?
- ❑ Have you thought about how you will deal with angry and hostile patients and families?

DISASTER PREPAREDNESS Continued

As the Bureau's representative, Lisa has shared with the committee that she feels that as a whole, most of the home health and hospice agencies have a disaster plan, and out of all the provider types she feels they are the best prepared. She feels the home health and hospice industry may have a slight advantage in dealing with this type of crisis as compared to other health care industries. During your every day work, you have to consistently exercise flexibility; in many cases improvising in delivering health care with little time to contemplate the challenges, while working independently with sometimes none to very little direction and supervision.

Some agencies may have a very basic and simple plan while others work on a more sophisticated plan. Whatever plan you have, we all realize that the best laid plans may not be good enough. The bureau realizes there are so many variables and assumptions that addressing the many facets of a pandemic flu can quickly become overwhelming. Lisa uses the analogy of a pandemic as compared to a football scrimmage. When a disaster hits it will be a very rough and tough struggle, but all the bureau can ask is that the agencies play the game to the best of their ability, and hope that all the planning and preparing has paid off.

Lisa is confident that the majority of the home health and hospices of Missouri are planning for a pandemic flu disaster. In the past 4 years you have demonstrated throughout the state that you functioned as best you could when other disasters, such as ice storms, power outages, floods, and tornados have hit. She knows that you always do the best job you can with what you have to work with, and as the regulatory body governing your agencies, that's all she can ask for.

Please see Attachment 3. This is a list of the bare minimum themes the bureau assumes all agencies have addressed in regards to pandemic flu planning. For some of you the plan may be as brief as a page or two; for others you may have a binder containing all the policies and procedures. Whatever the case may be, please take a few minutes to look over these nine themes. Under each topic there are discussion items. If for some reason your agency hasn't addressed these, PLEASE ACT IMMEDIATELY.



STAMPED PHYSICIAN SIGNATURES

In the July 2008 Bureau Talk, the Bureau published the new guidance on stamped signatures as noted in the CMS (Centers for Medicare/Medicaid Services) S & C (Survey and Certification) memo 08-22, dated May 30, 2008. However, with the new hospice regulations effective December 2008, several providers have phoned the bureau inquiring whether the new regulations have changed the guidance previously published.

As noted in the CMS S & C 08-22, home health agencies and hospices may no longer accept rubber stamp signatures from physicians on orders, treatments, or other documents that are a part of the patient's clinical record. CMS, with the publication of the new hospice regulations in December 2008, did not change this guidance.

DISCHARGE FOR CAUSE

In the April 2009 Bureau Talk, the Bureau stated that we did not need to be notified prior to a hospice agency discharging a patient for "cause". At this time the Bureau is retracting this statement with the following clarification.

The State Operations Manual (SOM), Chapter 2, Section on Hospice, is being updated in conjunction with the new federal hospice regulations that went into effect December 2, 2008. At this time, the document is in its final draft form and is in the internal clearance process at CMS. With the permission of CMS, please find section 2082 from the SOM on "Discharge for Cause" below.

"2082 – Discharge from Hospice Care

Once a hospice chooses to admit a Medicare beneficiary, it may not automatically or routinely discharge the beneficiary at its discretion, even if the care promises to be costly or inconvenient, or the State allows for discharge under State law. The situations under which a hospice may discharge a patient are addressed in regulation at 418.26 and include the following situations:

- The patient moves out of the hospice's service area or transfers to another hospice.
- The hospice determines that the patient is no longer terminally ill.
- The hospice determines under a policy set by the hospice for the purpose of addressing discharge for cause, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.

The hospice must do the following before it seeks to discharge a patient for cause:

- Advise the patient that a discharge for cause is being considered.
- Make a serious effort to resolve the problem(s) presented by the patient's (or other persons in the patient's home) behavior or situation.
- Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services.
- Document in the clinical record, the problem(s) and efforts made to resolve the problem(s).

Prior to discharging a patient for any reason stated above, the hospice IDG must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his/her review and decision included in the discharge note.

The hospice notifies its Medicare administrative contractor (MAC) and SA of the circumstances surrounding the impending discharge. The hospice should also consider referrals to other appropriate and/or relevant state/community agencies (i.e., Adult Protective Services) or health care facilities before discharge. "

The bureau has not in the past nor will we ever approve or disapprove a discharge for cause. To fulfill the requirements of the SOM, if a hospice determines a patient is to be discharged for cause, the hospice agency is to e-mail the bureau (Lisa.Coots@dhss.mo.gov) with the circumstances surrounding the impending discharge. Please identify the patient in your e-mail with the patient's initials only. This information will be placed in your agency file here at the bureau. Please note that if a complaint should be filed, the bureau is still required by regulation to conduct an investigation. Notifying the bureau of the discharge for cause does not exempt your agency from a citation if, during a complaint investigation, it was found patient rights regarding discharge were violated and/or your agency policies were not followed.

HOSPICE/LTC COORDINATED TASK PLAN OF CARE

CMS has identified the following four problem areas in providing hospice care in the Long Term Care setting:

- Care and services do not reflect the hospice philosophy
- Poor coordination, delivery, and review of the care plan
- Ineffective systems to monitor effectiveness of the plan of care for pain management and symptom control
- Poor communication between hospice and LTC staff.

The Missouri Association of Homes for the Aging and the Missouri Hospice and Palliative Care Association developed the Hospice in Long Term Care Work Group to address various hospice and LTC issues. This taskforce consisted of hospice, skilled nursing facilities, residential care and assisted living providers, and representatives of the Section for Long Term Care Regulation and the Bureau of Home Care and Rehabilitative Standards within the Department of Health and Senior Services.

The workgroup realized that for numerous years, coordinating care for the LTC hospice residents has been a challenge and the key to success is communication. Having that in mind, the work group set out to create a form that could be universally used by hospice and LTC providers.

What is the *Coordinated Task Plan of Care*?

The *Coordinated Task Plan of Care* is a plan that will promote optimal hospice care to residents in long term care by increasing the communication between providers. The intent is to assist in establishing and agreeing upon a coordinated plan of care/service plan which meets the resident's individual needs, preferences and living situation.

This form is recommended for use in skilled nursing facilities, assisted living facilities, and in the residential care settings for any residents receiving hospice care from a certified hospice agency. It will enable the hospice and LTC provider to utilize a process to assure quality of care by use of the Coordinated Task Plan to communicate, establish and agree upon care. Although this form is not mandated by regulation, the Section for Long Term Care Regulation and the Bureau of Home Care and Rehabilitative Standards support this document.

Please find attached the *Hospice/LTC Coordinated Task Plan of Care* and *Strategies & Tools to Improve the Coordination Process* dated June 18, 2009. (Attachment 4) For more information on this *Coordinated Task Plan of Care*, please contact Denise Clemonds at the Missouri Association of Homes for the Aging at 573-635-6244 or by e-mail at denise@moaha.org or the Missouri Hospice and Palliative Care Association at 573-634-5514.

ENTICEMENTS/INDUCEMENTS

The bureau continues to get phone calls from providers regarding issues that they feel are indicative of possible enticement or inducement. The bureau has met with the Office of Inspector General (OIG) regarding this issue. It is the recommendation of the OIG that if an agency has an issue that they feel may fall in this category; the agency should call the OIG hotline at 1-800-HHS-TIPS (1-800-447-8477).

Attached is a Medicare Learning Network (MLN) document dated January 2009, titled, "Medicare Fraud & Abuse" (Attachment 5). This Resource Reference directs you to a number of sources of information pertaining to Medicare fraud and abuse and helps you understand what to do if you suspect or become aware of incidents of potential Medicare fraud or abuse.

HOSPICE Q & A's

On May 21, 2009, two of the bureau's surveyors, Bonnie Quick, R.N. and Gerryann Wagner, R.N., did a webinar sponsored by the Missouri Hospice and Palliative Care Association (MHPCA) titled, "Surveyor's Here! Going Through a Medicare and State Survey". The objective of the webinar was for hospice agencies to see through the eyes of a surveyor, the new Medicare hospice Conditions of Participation that went in to effect on December 2, 2008.

As a result of the webinar, the bureau received several questions. We have now answered all the questions and have compiled them together for all hospice providers to view. Please see Attachment 6.

The bureau also realizes that not every hospice agency was able to view the webinar on the day it was scheduled. Therefore, please find attached, (Attachment 7) the handouts that went with the webinar as well as the presenter's notes.

HOSPICE WEBINAR TRAININGS

The bureau would like to remind hospice agencies about the free webcasts pertaining to the new hospice regulations that CMS has made available to agencies for viewing. Agencies can access these webcasts by going to <http://www.cmstraining.info/index.aspx> and clicking on "Archived Webcasts". There are four webcasts that pertain to the new hospice CoPs. They are:

1. Overview of the New Hospice Conditions of Participation, Subpart C (dated 1/22/09)
2. Overview of the New Hospice Conditions of Participation, Subpart D (dated 2/19/09)
3. Hospice QAPI Part 1: The QAPI Conditions of Participation (dated 3/13/09)
4. Hospice QAPI Part II: Hospice QAPI Requirements in Practice (dated 4/22/09)

The bureau highly encourages all hospices to view these webcasts. It is your agency's means of becoming even more familiar with the new regulations and the survey process associated with them.

DURABLE POWER OF ATTORNEY

Per Missouri Revised Statutes, Chapter 404, Durable Power of Attorney, Section 404.825, "Unless the patient expressly authorizes otherwise in the power of attorney, the powers and duties of the attorney in fact to make health care decisions shall commence upon a certification by two licensed physicians based upon an examination of the patient that the patient is incapacitated and will continue to be incapacitated for the period of time during which treatment decisions will be required and the powers and duties shall cease upon certification that the patient is no longer incapacitated. One of the certifying physicians may be the patient's attending physician. The certification shall be made according to accepted medical standards. The determination of incapacity shall be periodically reviewed by the attending physician. The certification shall be incorporated into the medical records and shall set forth the facts upon which the determination of incapacity is based and the expected duration of the incapacity. Other provisions of this section to the contrary notwithstanding, certification of incapacity by at least one physician is required. "

This is just a reminder to hospice and home health agencies that when a power of attorney is invoked, there should be documentation in the medical record supporting that two physicians have determined the patient to be incapacitated, unless the power attorney specifically states that only one physician is required.

HOSPICE TAGS

As you are aware, with the amended *State Hospice Regulations* in February 2009, an updated numbering system of the citation tags occurred. The "State Hospice – Certification" tool with the new numbering system was provided to you with the October 2008 Bureau Talk. On this tool you will find each citation tag labeled as a "ML" number.

The bureau has recently been informed that the computer software that is used to generate the Statement of Deficiencies after a survey is conducted will no longer be able to recognize the "ML" before the citation tag number. All citation tags, both federal and state will now be listed as "L" tags. Therefore, if you receive a Statement of Deficiencies report post survey, both the federal and state citation tags listed will all be prefixed with the letter "L". You will know which tags are for federal deficiencies and which ones are for state deficiencies by the form on which they are listed. If it is a federal tag, the form will be labeled as the "CMS 2567", if it is a state tag, the form will be labeled simply as "STATE" on the bottom of the page.

As a review, the state citation tags are numbered 100 – 537. The federal citation tags are numbered 500 – 801. As you can see there is a slight overlap in the numbers; however, those state citation tags numbered 500 -537 only pertain to inpatient hospices.

VOLUNTEERS

On May 8, 2009, Bonnie Quick, R.N. and Gerryann Wagner, R.N., presented at the "Volunteer Skill Building Conference" in Columbia, Missouri. The audience for this presentation was primarily volunteers. The topics covered in the presentation all pertained to volunteers in the hospice setting. A couple of the topics discussed were the state and federal regulations by which the volunteers must function and what types of things the surveyor looks for when surveying in the area of volunteers. Bonnie and Gerryann also compiled a list of the most frequently asked questions of the bureau in the area of volunteers and provided them with the bureau's guidance on these questions. Please find attached (Attachment 8), the information and handouts that were provided for the attendees.

VOLUNTEERS AND ELECTRONIC RECORDS

A question was recently asked of the bureau regarding how to handle documentation for volunteer visits when the agency is paperless and uses electronic medical records. In particular, can the RN enter the information for the volunteer and state "Per Jane Doe, volunteer,..." since volunteers don't normally have computer access?

Per state hospice regulation ML241 under *Central Clinical Records*, it states "Entries shall be made and signed by the person providing the services". In the federal regulations, 418.104(b), L679, under *Authentication*, it states "All entries must be legible, clear, complete and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice".

After review of the regulations, the bureau has determined that it would be expected that agencies who's volunteers do not have access to electronic records, should have paper copies of the visits the volunteers perform that are signed and dated by the person providing that service.

HOSPICE POLICIES AND PROCEDURES

The surveyors are finding on hospice Medicare surveys that agencies have not updated their policies and procedures to reflect the new hospice conditions of participation (CoPs). Due to the changes in the CoPs, many agency policies and procedures are no longer current and require updating.

This is a reminder from the bureau to all hospice agencies that policies and procedures must be updated to reflect the new CoPs or your agency could be subject to citations.

ADVANCE BENEFICIARY NOTICES

The bureau has received several phone calls lately regarding the Advance Beneficiary Notice of Noncoverage (ABN) for hospice as well as the Home Health Advance Beneficiary Notice (HHABN) for home health.

Per CMS, *hospices* are to be using the ABN, Form CMS-R-131 as applicable. The forms and instructions can be found at http://www.cms.hhs.gov/BNI/02_ABN.asp#TopOfPage. This ABN form is dated 03/08. There has been a grace period for the last year but effective March 1, 2009, the old ABN-G was no longer valid.

The HHABN form does not apply to hospice care. Per CMS, *home health agencies* are the only providers instructed to use the HHABN. The *current* HHABN with the expiration date of 8/31/09 is posted on the CMS website at http://www.cms.hhs.gov/BNI/03_HHABN.asp#TopOfPage. There is a *revised* HHABN, Form CMS-R-296, which has not yet received final approval for use. The expiration date on the current form will be extended pending approval of the revised form and will allow time for HHAs to transition between the two forms. Details will be announced on the web page listed directly above and at the Home Health Open Door Forum in the near future.

For all documentation related to the new proposed HHABN go to http://www.cms.hhs.gov/PaperworkReductionActof1995/downloads/CMS_R_296.zip.

Combined Home Health Agency/Hospice providers must use both of these notices as they are applicable – the ABN for beneficiaries who are enrolled in hospice and the HHABN for those with a home health plan of care.

Because the ABN and HHABN forms address financial issues, any questions regarding the form should be addressed to your fiscal intermediary by calling The Cahaba Customer Service Line at 877-299-4500.

DURABLE MEDICAL EQUIPMENT

This is just a reminder to hospice agencies that the new hospice regulation governing durable medical equipment services takes effect September 30, 2009.

Regulation 418.106(f) (3), L703 states: "Hospices may only contract for durable medical equipment services with a durable medical equipment supplier that meets the Medicare DMEPOS Supplier Quality and Accreditation Standards at 42 CFR 424.57."

Per the Interpretive Guidelines: "DMEPOS is the acronym for Durable Medical Equipment Prosthetics, Orthotics and Supplies. All DMEPOS suppliers are required under separate rulemaking to be accredited by September 30, 2009, in order to receive Medicare payment.

- If a hospice has a contract with a DME supplier (that has a Medicare supplier billing number), the hospice should have a letter in its file from the DME supplier stating that the DME supplier is accredited.
- If the hospice contracts with a DME supplier that only serves hospices, (therefore no Medicare supplier number), the hospice will still need to have a letter in its file from the DME supplier stating that the DME is accredited.
- If the hospice owns its own DME, no accreditation is needed."